Original Article

Investigation of retention and destruction process of medical records in the hospitals and codifying appropriate guidelines

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ABSTRACT

Introduction: One of the major issues in hospitals is the period for which the medical records are retained. Health information management professionals traditionally have performed retention and destruction functions using all media, including paper, images, optical disk, microfilm, DVD, and CD-ROM. Health information management departments must maintain a specific program to retain and destruct the records. The purpose of this paper is to investigate the retention and destruction process of medical records in the hospitals in Isfahan and codifying the appropriate guidelines. **Materials and Methods:** The research was conducted as a cross-sectional descriptive study in 30 hospitals in Isfahan. The data was collected using a Check List. Also 30 medical records experts' viewpoints were obtained using the Delphi technique. Data entry and statistical analysis was performed using SPSS. **Results:** The findings indicated that 53.8% of the study population maintained a written policy. A 34.6% maintained a written policy to destruct medical records. And 50% announced that no instructions had been given to the hospitals by qualified authorities to destruct the medical records. **Discussion:** The majority of the hospitals are still unclear about the retention period of medical records, which could be due to not to mention the retention period for most medical records by the country's National Literature and lack of policy and procedure in hospitals. **Conclusions:** According to the legislations, hospitals are bound to retain the inpatients' records for full 15 years but based on the findings of this research, less than half of the study population retained the inpatients' records for the period mentioned.

Key words: Destruction, medical record, process, retention

INTRODUCTION

Retention of medical record is an important matter in a health care facility. Medical records must be maintained by a facility to support patient care; meet legal and regulatory requirements; achieve accreditation; allow research, education, and reimbursement; and support facility administration. The duration of record retention differs for the various types of records kept (eg, laboratory data, radiology reports and films, fetal monitor strips, birth certificates, Master Patient Indexes) and for different facilities (eg, physicians' offices, hospitals).[1]

Moreover, medical record serves many diverse purposes in the daily operations of a health care organization. It allows a patient's health care providers to communicate with one another; provides a basis for planning a patient's course of treatment; documents the quality of care for review at a later time; provides a source of information for statistical analyses; and establishes a basis for the billing process and the generation of financial reports.[2] So, it is important to know

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Access this article online	
Quick Response Code:	Website: www.jehp.net
	DOI: 10.4103/2277-9531.112687

This article may be cited as: Tavakoli N, Jahanbakhsh M. Investigation of retention and destruction process of medical records in the hospitals and codifying appropriate guidelines. J Edu Health Promot 2013;2:17.

how long a health care facility must keep medical records. The length of time a record is kept by a facility is the record retention schedule. Health information professionals are frequently asked questions about how long to keep patient records. There is no universal answer to the question.[3]

On the other hand, there are circumstances when it is appropriate to destroy health information. For example, records may be destroyed at the completion of the retention period. Destruction of records should take place only after approval by the facility and complete details of all records destroyed must be kept indefinitely.[4]

According to the policies, procedures and the professional standards, facilities should establish a record retention schedule. When the duration time of retention is completed, the record will be disposed. The health care facilities must consider policies, procedures, governmental laws, and accreditation standards.[5]

Several factors need to be considered deciding about medical records retention time, including the number of inactive records, the rate of readmission of patients, financial estimation of space, staff and equipment, accessible and usable space, the status of limitation, research and education, especially in teaching hospitals, types of records (mental health records, heart diseases records, emergency records.), types of health care facilities (long-term facilities, short-term facilities, general or specialized hospitals).[6] The health care facilities' policy is an important factor that needs to be considered in disposing the records.[7]

A descriptive study entitled "medical records retention schedules" in 250 hospitals in the USA showed that there is one or more medical record policies in all hospitals. Also it indicated that 63.1% of hospitals maintained paper records permanently.[2]

According to the point of views of 526 physicians about medical records retention time in the USA, 41% believed that medical records should be maintained for 7 years, 6% for 10 years, 15% for 15 years, 14% for 20 years, and 24% agreed with more than 20 years. Rural hospitals and general physicians proposed shorter retention period than the specialized hospitals. Physicians' ideas were different so most of them believed in maintaining records for more than 15 years.[8]

In Isfahan hospitals there are no regular and similar procedures, which make many problems in medical record departments, including wasting money, time, and human resources in medical record retention; occupying a huge space due to existing inactive records with no disposition procedure; and shortage of space for active records, which have not passed the transferring or disposition period.

There is no unlimited storage for record maintenance, so it is necessary to have a proper plan and schedule to avoid mass records. Due to space limitation, many hospitals maintained patient records in unsuitable and unsecure conditions and it is difficult to retrieve them at real-time.

This research aimed to investigate the current period of the medical record retention and disposition process and provide united standard guidelines based on the country's National Literature and point of views of medical record professionals and academic members in universities.

MATERIALS AND METHODS

This cross-sectional descriptive study was conducted on medical record departments of 30 hospitals in Isfahan. Data were collected by a made-researcher checklist in three sections: hospital identification, policies and procedures regarding record retention schedule, and disposition. In order to collect data the researcher referred to the hospitals' medical record departments and filled the checklist. Four hospitals didn't cooperate and were excluded. Using Delphi technique, the point of views of 30 academic members and experts in medical record and health information management fields about retention time and destruction of medical records were collected. Data were analyzed by SPSS and frequency distribution was detected.

RESULTS

A. The investigation findings about the medical record retention policies and procedures: It was confirmed by 53.8% of the hospitals that they maintained written policies about medical records retention time. A 57.7% of hospitals announced that the retention schedule guidelines were authorized and sent to them by the related authorities. Fifty percent revealed that the medical record retention schedules were established in hospitals' medical record committee. A 46.2% expressed having written policy to purge the medical records. Sixty-five percent announced that no schedule was sent to them by the responsible authorities in order to purge the medical records. Fifty percent of the studied population said that no guidelines for purging the records were established by the medical record committee and 15.4 percent didn't respond.

B. The investigation findings about medical record destruction policies and procedures:

Only 34.6% of the studied hospitals had a written policy for medical records disposition. It was revealed by 50% of the study population that no disposition guidelines were sent to them by the responsible authorities. A 53.8% said that no guidelines were established by the medical record committee in order to dispose the medical records and 15.4% did not respond.

The findings related to the second objective of the research, identifying the inpatient medical records retention time, were as follows:

Forty-four percent of hospitals retained the inpatient records for 15 years, 20% for less than 15 years, and 36% for more than 15 years.

The war-related injury records were retained permanently

in 85% of hospitals. Also 58.4% of hospitals kept the cardiovascular diseases and mental health records permanently.

The findings related to the third objective of the research, identifying the outpatient medical records retention time, were as follows:

A 26.1% of hospitals retained the outpatient records for 5 years, 56.2% for less than 5 years, and 15.4% for more than 5 years.

The outpatient records with legal issues were retained permanently by one of the studied hospitals (7.7%). The other hospitals (50%) reported various retention times between 3 and 25 years of which the 25 years was related to a private hospital.

In identifying the emergency records, retention time in Isfahan hospitals as the fourth objective of the research, the following were obtained:

The emergency records were retained for 3 years in 65.4% of hospitals and 3.8% of hospitals retained the records for 2 years.

The fifth objective of the research, identifying the indices cards retention time, indicated that the majority of the studied hospitals (50%) retained them permanently.

The findings related to the sixth objective of the research, identifying the admission and discharge registration log retention time, were as follows:

The majority of the studied hospitals (50%) retained the record permanently; and 15.4% retained them between 3 and 15 years and 34.6% had no admission and discharge registration log was in a paper format.

In identifying the retention time of other registration books in Isfahan hospitals as the seventh objective of the research, the followings were obtained:

The majority of the studied hospitals (38.4%) retained the wards' report books for 3 years. Most of the hospitals (26.9%) retained the supervisors' report books permanently and 19.2% retained them for 15 years but the vast majority of hospitals (61.6%) did not identify the retention time of medicines books and 11.5% retained them for 3 years.

Fifty percent of hospitals did not make any response regarding the retention time of diagnosis laboratories admission registration log and 19.2% retained them for 3 years.

Investigating the retention time of radiographic negatives in Isfahan hospitals, the 8 research objectives indicated as given below.

Most hospitals (25%) maintained the records for 3 years. One of the hospitals retained the radiographic negatives permanently and the others between 5 and 20 years.

The final and the ninth objective of the research, identifying the retention time of the medications' record, revealed the following.

The majority of hospitals (58.4%) retained the records for 3 years. One of them (7.69%) expressed its retention time 2 years and the others declared it between 5 and 16 years.

Finally, a proposed medical records retention schedule was provided by the researcher using Delphi technique, which is presented in Table 1.

DISCUSSION

According to the finding of this research, the majority of the hospitals are still unclear about the retention period of medical records, which could be due to two reasons: first and the most important reason is that the retention periods for most medical records are not mentioned by the country's National Literature and the second reason is that no specified policy and procedure is codified by hospitals for this important issue. In addition, hospitals do not maintain a regular and written procedure to retain and destruct the hospitals' medical record.

In Britain, all institutes covered by the National Health Services are responsible to establish a framework to produce, storage, retrieve, manage, and dispose the health information in order to be able to respond to the legal requirements and

Table 1: Proposed medical records retention time

Proposed time	Country's national literature	Type of record
Up to 25 years	No specific rules	Infants
Permanently	No specific rules	Obstetrics
Permanently	permanently	Cardiovascular disease
15 years	15 years	Other inpatient
3 years after last referral	No specific rules	Mortalities
10 years after death	3 years	Emergencies
5 years after last referral	5 years	Outpatients
10 years after legal age	No specific rules	Artificial inseminations
25 years	No specific rules	Oncology
7 years	10 years	Radiography records
15 years	15 years	Radiography records educational
Permanently	No specific rules	Birth and death certificates
Permanently	No specific rules	Disposition records
25 years	No specific rules	Genetic recodes
25 years	No specific rules	Cancer, diabetes, and AIDS registration records
10 years	No specific rules	Accidents and incidents registration records

determine the record retention regulations and its time schedule regardless of the records' retention methods.[9]

The findings of the study indicated that the majority of hospitals have no written policy to purge and dispose medical records and no guidelines were sent to them by the related authorities and also there were no guidelines codified by the medical record committee.

In a comparative study of medical records standards in selected countries by Meydani, it was revealed that in contrast with the studied countries, there is no responsible proctor in Iran to codify the standards related to medical record documentation, confidentiality, access, and retention and disposition time.[10]

According to the legislations, hospitals are bound to retain the inpatients' records for full 15 years but based on the findings of this research, less than half of the study population retained the inpatients' records for the period mentioned and it is believed that there should be complete control over the implementation of the above legislations by the authorities to maintain and protect the medical record so that no detriment is caused in case of any future usage of the records and also the rights of patients who are the most important users of these records are preserved.

Medical records are valuable resources due to the importance of information they hold, therefore high-quality information is an indicator of high-quality health care. The information will be valuable if they are accurate, current, and accessible. The effective management of health information should guarantee appropriate information management and access by authorized users in any time and place required.

While the current 5 years retention time is clearly defined in all hospitals' guidelines, the majority of studied hospitals retained the outpatient records for less than 5 years and unfortunately the guidelines were ignored by the hospitals.

The findings of the study showed that most hospitals retained the ward and supervisors' reports permanently, whereas they are authorized to dispose them after 2 and 15 years, respectively, and make the space free to keep the other records.

Unfortunately most hospitals are careless regarding the retention of radiology negatives, which are important records for patient care to avoid radiation re-exposure, and even these records were retained for less than the determined time. Therefore, this issue must be controlled by radiologist and medical record practitioners.

The majority of hospitals did not respond to the query about the retention time of treatment fee receipts and medication records, but this is identified by guidelines for at least 3 years.

The finding of the current study with regard to follow of the current retention policies did not comply with the findings of the descriptive study called "medical records retention practice patterns in acute care hospitals in the United States." In the current study even "level one" hospitals ignored the country's National Literature's guidelines. But the American research revealed that 95.1% of the institutions usually or always followed the retention policies and only 4.9% were believed to ignore them. "Level three" institutions had the highest percentage of complying with the policies.

According to the findings of the current study, it is concluded that hospitals do not maintain a regular and written procedure to retain and dispose the hospital medical records. Some hospitals do not even comply with the only available policy with regard to the retention period of the medical records, which causes extra tension for the medical records personnel because it is time consuming and in some hospitals could lead to early destruction of the documents. This also highlights the need for serious supervision of the medical record authorities.

The results of study of record-keeping in NHS hospitals in England were found to be of poor standard and corrective action was recommended; one of the key issues was the low priority given to records management.[11]

Finally, there is no written disposition instruction in the hospitals in Isfahan and some of them have received separate authorizations in co-operation with the university's legal representative and the country's National Literature representative to dispose the records. But it is specifically enjoined that this process is managed carefully by the university's medical records group deputy to ensure that no records are unwillingly destructed.

The medical records departments in hospitals, in co-operation with other units and based on existing policies and procedures and also according to the external guidelines sent by the related authorities, must develop a retention schedule for various types of records. In the meantime, the security and accuracy of the records are guaranteed in order to maintain patient care, legal, educational, and financial research. And then the destruction process is done after the completion of the retention period.[3]

The researcher codified some guidelines for retention and destruction of medical records in Isfahan to carry out this processes in a proper manner in hospitals, which are presented in the next section.

Suggested guidelines

(1) Each hospital should provide detailed medical records retention and disposition guidelines and these guidelines should be approved by the medical record committee. Also the guidelines should provide a response to the following questions:

a. Which records should be retained permanently?
b. How long the various types of records should be maintained?
c. Which records should be disposed or transferred to the secondary storage area?
d. Who is responsible to dispose or transfer the records to

the secondary storage area?
e. What are the records retention or disposition terms and conditions?
f. What are the records accessibility conditions in the secondary storage area?
g. What are the legal requirements and status of limitation for hospital medical records?

(2) In order to dispose the medical records, the hospitals should act in accordance with the legal authorizations and the country's National Literature representative.

(3) The medical record managers should completely monitor the retention and disposition process in accordance with the medical records committee approvals and apply the scientific text cited rules as below:
a. Determination of the date of disposal preferably at the end of the month or year
b. Assigning one or more persons, with registered identifications available to hospitals, for disposal process
c. Organizing the records which are going to disposed
d. It is important to dispose the records on time to avoid waste of money on records storage, retention, and dealing with legal enquires.
e. Records confidentiality must be maintained and controlled by the medical record manager during disposal process, especially when the job is done by private service companies.
f. Abstracting should be done for all disposed records
g. All of disposition records must be documented and retained

Recommendations

a. The medical record committee should develop the record retention schedule and formulate disposition guidelines in hospitals.
b. Based on the country's National Literature authorization, the Chief Executive Officer (CEO) and the medical record manager must completely observe the retention and disposition process.

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Source of Support: Nil, **Conflict of Interest:** None declared